Informed Opinion

Long Range Expectations for the Health Delivery System

GERALD BESSON, M.D., *Sunnyvale*

ONE OF THE MOST pervasive characteristics of society today is the feeling that the entire system is somehow devoid of human control. The individual has a sense of powerlessness that he objects to increasingly. Things are being done but no one is quite sure how to influence the decision, and an air of alienation abounds.

On reflection, however, we know that there are powerful and diverse forces in our democratic society, each with its direction of push and each with its particular magnitude, all culminating in a vectored decision that represents a summation of all these pressures. The forces are often hidden but they are discernible and they are subject to influence and to balance. They exist in the health care field and are constantly applying their strength and directions of pressure on the status quo in our health delivery systems. Coalitions are made and broken, power blocs gain and lose strength, new partnerships are formed and dissolved, traditions are swept aside, and what was certain yesterday is forgotten today in a cauldron of change that makes prophesy in health care systems hazardous.

I would like nevertheless to try to interpret some of the long range expectations in health delivery systems of the major forces playing dominant roles in health care today.

First, a definition of *health delivery systems.* The term has a wide variety of meanings. One may consider that the primary problem of health delivery is fiscal, while others may be most concerned with accessibility. Pressure to change the former may do nothing for the latter.

We are currently imbued with cost considerations, yet no degree of fiscal infusion or cost controls in our health care systems will relieve manpower shortages, as is now painfully apparent to all. As we talk and read about delivery of health care, we should be aware that we may be blindly feeling a different part of the elephant.

There are four distinct power blocs affecting health care: the federal—both administration, and congress; the provider; the social planner; and the consumer.

The Federal

Administration expectations for health delivery systems may be best defined by the broad philosophical attitude of President Nixon toward health and other domestic problems in a letter he wrote to Robert Finch, when he was Secretary of the Department of Health, Education, and Welfare. He writes:

> "Dear Bob: John Gardner's Godkin lectures express better than anything I have read what I hope will serve as a basic philosophy of this Administration."

Gardner says:

> "Housing, education, health, employment and discrimination problems are exceedingly resistant to solution. They may be insoluble until society has made better problem-solving mechanisms. Needed, would be more effective federal-state-local relationships, more fruitful

Presented at a Workshop on Comprehensive Health Planning: Roles and Goals in Personal Health Services, September 19, 1970, San Francisco, sponsored by the CMA Committee on Comprehensive Health Planning.

Reprint requests to: CMA Committee on Comprehensive Health Planning, 693 Sutter Street, San Francisco, Ca. 94102.

relationships between the public and the private sectors and making governments at all levels more responsive. If we want a society on a beehive model, all we need do is relax and we'll drift into it. If we want a society built around the creative possibilities of the self-directing individual, then we have tasks to perform. Political experts are beginning to realize that the Federal Government, too, has its weaknesses. They are discovering that too much centralization falls of its own weight, that the Federal Government cannot, and as a matter of sound procedure should not solve complex local problems. They are now beginning to see that the Federal Government can insure its future vitality and effectiveness only by making more fruitful and flexible delegations of power to state and local government and to the private sector. Forces now at work tend to squeeze our pluralism and to move us toward one comprehensively articulated system of power. We must work against that trend. As I contemplate that trend, I find myself treasuring every remaining bit of pluralism, everything that stands between us and the one all-embracing system."

The President's letter was written in early 1969. Since then, several events have further clarified the administration's position:

1. Much evidence of fiscal restraint on Health, Education, and Welfare expenditures, including decreased appropriations as well as a growing disparity between authorizations and actual funding. HEW appropriations in 1969 were 80 percent of authorized amounts, 50 percent in 1970 and 42 percent proposed for fiscal year 1971.

2. The removal of Finch from HEW downgrades the primacy of Health as an administration priority. This is further evidenced by a recent report by the Administration's staff on National Goals, in which health was not even mentioned.

3. There is not a shred of evidence that the Administration is at all inclined toward a national health insurance program. If anything, the guaranteed annual income program, so high on the President's priorities for Congressional action is an income program, not a service program and even this may not get off the ground.

4. "The concept of the health maintenance organization," Under-Secretary of HEW John Veneman states, "seeks to reverse the need for piecemeal federal intervention in the delivery of health services." In effect, this option is offered as an attempt to test the contention of cost savings of the group prepay concept. At best this is a lukewarm Administration move toward changing the organization and delivery of health.

5. Finally, the principles of creative federalism so often alluded to by the Administration involve decentralization, revenue sharing, block grants, and the retention of pluralism throughout the health establishment. All of these principles, as well as income strategy for the welfare program do not add up to much enthusiasm for a federally controlled health industry.

In summary, then, the Administration as one of the two major federal forces seems satisfied to digest what the 89th Congress created before it proposes any major changes.

Any shift from this position will only develop in response to political pressures by those seeking to modify the status quo.

The Congress represents a balancing force to the Administration position. Its direction is varied, depending on the political persuasion of the legislator concerned. Several bills have been introduced by various congressmen which reflect the views of varying constituencies on the need for change in health delivery systems. The four major ones are the Medi-Credit Bill, representing the American Medical Association view; the Griffiths Bill, representing the position of the AFL-CIO; the Javits Bill, presumably representing Mr. Wilbur Cohen's influence; and the Kennedy Bill, representing the Committee of 100 for a National Health Insurance, headed by the late Walter Reuther. Other versions of the Kennedy Bill have been introduced by Yarborough, and two congressmen from New York and Illinois.

I will discuss each of these only in brief outline.

The AMA plan is to provide tax credits to purchase a standardized health insurance package. For a person with under $300 tax liability, a certificate is provided for such a purchase. The cost is ten billion a year but no change in delivery systems is proposed by this program, which basically provides money for purchase of care in the marketplace.

The Griffiths Bill sets up regional agencies to contract with groups to provide health care. There would be deductibles. For the patient payment would be per capita or by salary, as the contracting groups decide. An employee-em-

ployer tax plus general revenues would fund the program of approximately forty billion per year.

The Javits Bill expands Medicare to include everyone. The Secretary would contract with employers, with groups, or with insurance carriers to provide care. A payroll tax and general revenues would fund the program, estimated at sixty-six billion a year when fully funded.

The Kennedy Program would provide coverage for everyone, effectively eliminate fee for service practice, empower regional planners to accredit institutions and presumably also accredit providers and would be financed by an employer-employee tax and general tax revenues for a fifty billion dollar a year package.

Let us look at the introduction of the Health Security Act of Senator Kennedy in the Congressional Record of August 27th:

> "Today in the United States, it is widely recognized that the American people are confronted with a crisis in the availability and delivery of essential health services. In spite of the broad agreement that our population has a right to health care, the evidence is overwhelming that this right cannot be adequately exercised by most of our people. The nature and dimensions of our national need for a system of better health care are well known. If we are to avoid the collapse of our health services and the disastrous consequences that would ensue for tens of millions of our people, we must take action."

These ringing words, which go on for 25 pages of fine print in the Congressional Record, seem to be said in preparation for a great political confrontation at some time in the future.

Maneuvering for advantage in this struggle was evident by the Administration's testimony on the Kennedy Bill where it was stated that "actuarial estimates of the Social Security Administration for expenditures of the first full year of operation would come to $77 billion. This is equal to about half the total present general revenues of the Federal government and would be equivalent to a Federal health tax of over $1,000 per year for every household in the United States."

In effect, however, the Congress seems to be saying that these four proposals and others in the wings will be a means of sounding out the national mood. Would that were so. Rather, one gets the impression of political opportunism, of a multi-headed creature without a central nervous system, ready to react, knee-jerk fashion, with all of its tremendous power, far removed from the public and not really knowing the public's needs. It responds not with rationality and statesmanship, but rather to its assessment of what will seem to be the most politically successful move.

The Provider

I shall restrict my discussion to the major provider, the physician. While he is rapidly losing that distinction of being the major force among providers, he is still the key figure in health delivery. Traditionally, all health services revolve about his judgment and decision. Even now, *his* orders are the source of all health care costs. He orders hospitalization or does not. He orders treatment or does not. He orders diagnostic procedures or does not. Unless he is consulted, no costs are incurred and no delivery of services is effected. For this reason he is sometimes erroneously blamed for a variety of shortcomings of the entire system. His expectations? Most physicians are too busy to have thought about changes in health delivery. I suppose many are concerned about the pressures for change, but also most are not aware of the inequities of the present. For a variety of reasons, the physician's influence is waning and is being supplanted by that of the emerging dominance of the social planner.

The aura of mystical knowledge and power of the physician in his healing art has somehow cloaked him with an undeserved omniscience. It is only in our age of specialization that the medical specialist is being divested of this cloak, and in affairs of public health his advice is increasingly being discounted. His lack of background in a variety of new disciplines has further eroded his credibility and has replaced him with this new breed of advisor, one who has knowledge in sociology, economics, planning, systems analysis, management, and a dozen other disciplines that bear on today's health problems.

Lack of knowledge in these fields has reduced the physician to the role of technician. However, the tried and true is hard to give up and he is reluctant to acknowledge that history is passing him by and changing his status from knight to yeoman. While he is a hard-working, dedicated, knowledgeable expert in his field, with an hon-

orable ethic and great heritage of professionalism, it is all devoted to the concept that the patient he is confronting is all that matters, as it should be. However, his simultaneous unconcern for the universe of non-patients is his downfall. So the traditional decisions about health systems which were exclusively his are rapidly dwindling and all that he senses is a vague restlessness that someone else is taking over his exclusive territory.

This inexorable trend produces anxiety and cynicism, misdirected fury and solemn but irrelevant rhetoric. Eventually, as all of us here know, apathy and withdrawal result. All at a time when society needs him most, for we are beset by experts who see many inequities in health services and in their econocentric and egalitarian zeal, may put a straitjacket around us all, provider *and* consumer, with changes that may be far wide of the mark, the good having been junked with the bad. Medicine is an intensely personal service. It *is* inefficient and, as with any other act of love, it is not well given to industrial efficiencies. However, in defending that bastion, the profession seems to resist all attempts at change.

The most exquisite study of the variation in expectations and attitudes of physicians toward changes in health delivery systems is contained in a report prepared by the AMA Committee on Planning and Development, called the Himler Report. It was reviewed, amended and passed by the AMA House of Delegates this year. This landmark document is a remarkable point and counterpoint of divergent forces among physicians. Let me give you a few samplings:

> Recommendation II: "The committee recommends that the AMA recognize the need for new and improved methods of delivering health services and that it encourage and participate in efforts to develop them." The substitute recommendation that was adopted reads: "The committee recommends that the AMA recognize the need for multiple methods of delivering health services." Note that *new and improved methods* change to *multiple methods.*" The implication, of course, is that no new and improved methods are needed, that current ones are satisfactory, although diversity is perfectly all right.
>
> Recommendation V, Part V: "The committee recommends that the constituent and component medical societies seek the active involvement of medical centers and voluntary hospitals in health services projects for the medically underprivileged." The following substitute resolution was passed by the House of Delegates:
>
> "The Committee recommends that the constituent and component medical societies seek 'the active cooperation of all physicians, both as individuals and members of medical staffs.'" Here we now read the *cooperation of physicians* rather than the *involvement of medical centers and voluntary hospitals.* The implication is that it is OK for physicians to cooperate but, for heaven's sake, let's keep those other meddlers out of our private poaching grounds—namely, "health service projects for the medically underprivileged."

Did I say health service projects for the medically underprivileged? Change that, said the House of Delegates, to medical service projects. The emphasis is on medical service. That is what a physician does. If the word health is used, the House of Delegates might recognize a breadth of service that would allow some strange camel's nose in the tent. As if this were not enough, the House of Delegates then deleted the words *medically underprivileged* and substituted the words *areas in need of medical services.* They are not underprivileged, the House implies. No, they just happen to be little short of medical services at the moment. And on and on for 20 recommendations, each struggling tortuously to balance those who seek change with those who will never let go of the past.

To recapitulate the physicians' expectations, we then see a large number of individuals who are immersed technically and cannot effectively make decisions responsive to consumers' needs because in their devotion to the individual they are blind to the collective. They cannot see the forest for the trees. They are being diminished to the role of technician and by-passed where decisions are made. In their place now emerges a third force—the social planner.

The Social Planner

Let us turn to this group that is assuming the advisor's role, replacing the physician as counsellor. It is a power bloc which is not organized, has no allegiance to a group, and consists of individuals who have independent and sometimes diverse ideas and communicate them well.

Their stock in trade is their creative vision. They act as technical advisors to all seats of power and strongly influence the thinking of the groups that act. They write, they speak, they testify at Congressional hearings, they are broadly knowledgeable, are articulate, and are totally unknown by the public. Their influence belies their numbers but they are an open-ended ad hoc group. You, too, can join. Let me give you a few examples.

The New York *Times* reported not long ago on President Nixon's address to Congress on Administration proposals. It was described as a twelve thousand word message, shaped by Daniel Patrick Moynihan, Counsellor to the President on Urban Affairs. Nonetheless, the speech is described as outlining the President's own governmental philosophy.

Mr. Nixon said in this address:

> "Society must reform its institutions to meet the present social reality of our post-industrial society where the problems surround the question of choice, what kind of life would we live, what kind of society would we have, growth for what purpose and with what consequences?"

Does this represent Mr. Nixon's views or Mr. Moynihan's views?

What about health delivery? Let me read to you from a report published earlier this year by the American Public Health Association entitled "Health Crisis in America" and representing a survey of health conditions in the United States by the presidents of the American Public Health Association for 1969 and 1970, Lester Breslow and Paul Cornely. I quote from the introduction:

> "As Public Health physicians, we thought we knew pretty well the nature and extent of those conditions, but frankly, we were shocked and are still reeling. Circumstances that can only be called health brutality pervade the lives of millions of American people who live in communities that seem designed to break the human spirit. When viewed closely, the national and state programs which purport to deal with these conditions appear to represent a policy of domestic brinksmanship. They simply skirt disaster and do little to ameliorate underlying problems. President Nixon recently spoke about a massive crisis in health care and warned that we will have a breakdown in our medical system 'which could have consequences affecting millions of people throughout the country.' In fact, this report goes on to state, 'the breakdown has already occurred and the consequences are already affecting our people.'

Here are two social planners who are of tremendous influence, both publicly and privately, in shaping opinion.

Another example: The Kennedy Bill is an outgrowth of the Committee of 100 for Nation Health Insurance. Let me give you an excerpt from the Congressional Record of August 27th:

> "The bill that we introduced today is based on the recommendations of the Committee. Throughout its deliberations, the Committee was guided by the work of its distinguished technical subcommittee, chaired by Dr. I. S. Falk, Professor Emeritus of Public Health of Yale University and the most eminent authority in the field of health economics in the nation."

I guess if Dr. Falk is *the most eminent* authority no further discussion is needed and we might just all sit down and hear the gospel. But who ultimately is the author of the Kennedy Bill? Kennedy? Walter Reuther? The rank and file auto workers? Or I. S. Falk?

What is the inestimable impact of this unseen power bloc on the direction on the future of health delivery systems?

Another example: Leonard Woodcock, succeeding the late Walter Reuther as President of the United Auto Workers and President of the Council on Health Insurance, has asked support of this package, the Kennedy Bill, in the union's demands in negotiation for contracts with the auto manufacturers. Will the appearance of support by business for a national health insurance program then be at the behest of the auto industry itself or at the behest of Leonard Woodcock, representing the organized consumer? It is reasonable to inquire into the distant origins of the conventional wisdom about health care delivery.

Finally, let me again refer to the Health Maintenance Organization, Part C of Medicare. "The main architect of the Health Maintenance Option for financing and providing medical care under Medicare and Medic-Aide sees it as possibly the last hope for the medical profession to retain control of the delivery system," reports the AMA American Medical News of May 18th.

"Paul Elwood, Jr., M.D., at whose American Rehabilitation Foundation at the University of Minnesota the plan was developed over the past three years, says the newly proposed legislation amounts to an alternative choice for the consumer."

Undersecretary John Veneman of HEW has stated that the Health Maintenance Option "seeks to reverse the need for increasing piecemeal federal intervention in the delivery of health services." We have already noted that this represents a movement on the part of the Administration toward restructuring of our health delivery system. Did the Administration order Part C created, or did someone create Part C and the Administration buy it? Where was the force for change? And whose expectations were served by Part C—Veneman's, Finch's, Nixon's, or Elwood's?

The point is that opinions about what is wrong with our Health Delivery Systems are varied and opinion makers abound. They have often insinuated themselves into positions in which they can wield immense power by leverage on others. I don't object to this, but it demands informed and responsible involvement of us all as a countervailing force against any who may be not acting in the best public interest. What about this audience? Are you as powerless as the alienated in our society would have us believe? Or are you knowledgeable and actively involved?

Consumer Expectations

Let us consider *Consumer Expectations.* While the previously mentioned groups, the Federal, the Providers, and the Social Planners, are extremely powerful, the consumer is only beginning to understand how to apply pressures where they count. Given this emerging consumer power, what do we know about consumer expectations? Very little hard data, I'm afraid, and much hearsay. Organized consumers, especially labor, are articulate and potent, but what about the large unorganized majority? They are, indeed, silent because no one has asked them. Yet there seems to be a conventional wisdom about their needs, their complaints, and their dissatisfactions with their health care. To hear the reports of the Columbia Broadcasting System, and to read *Fortune* and *Saturday Review,* one would think that there is nothing worthwhile about health systems in our country. There is only imminent collapse and all is woe.

In Santa Clara County, we did ask consumers what they expected. Some of the results are included in our Comprehensive Health Planning Association's abstract, "Framework for Health," and there are some startling conclusions about Santa Clara County. In one study, we did a random survey of fifteen hundred households in the county. Our final results are not in yet, but I was surprised to learn that 72 percent of respondents are satisfied with their care—satisfied specifically with availability, accessibility and acceptability. The sample was one-half of 1 percent of households in the county—not a large sample but one which is a statistically sound cross-section of income, race, geography. A small sample in one small corner of this great country, but interesting enough to make one wonder whether our headlong rush to junk the system is based on hard data.

Our Comprehensive Health Planning Association went further. We held several area conferences for citizens to speak out on health issues. They were revealing and poignant. For there we began to hear from many of the poor, whom nobody seems to listen to. The complexion here was different from our random sample, and our planning association was infused with findings from an entirely different subculture.

The in depth study of the Gardner district, which is only alluded to in our abstract Framework for Health, was another survey done. This was exclusively involved with the culture of poverty and produced a picture that is so depressing that the task of ameliorating the health status of these people seems almost hopeless. This study was done in a district of San Jose where 40 percent of the people live in poverty (as officially defined) and the rest in near poverty and reveals the stark reality of a group that is far outside the mainstream of middle class medicine. These consumers represent the twenty-five million of our country's population who are in want.

I would like to dwell on this group for the moment because they represent the heart of the problem. This group causes many to question whether our free enterprise system can tolerate the inequity of so tremendous a disparity be-

tween our affluent and our poor. The cost of poverty is far more than welfare or health costs alone. Recent studies showed that in some areas slum populations of 20 percent account for 60 percent of county health services usage, 76 percent of its tuberculosis, 41 percent of its juvenile delinquency, 42 percent of its adult crimes, yet paid only 12 percent of the taxes. The cost of the poor to society is far greater than its welfare costs, greater than its Medi-Cal or county health costs. It is a vastly greater sum than has ever been figured. This poverty-stricken consumer has little expectation of improving health care delivery systems because he is overwhelmed by the entire socio-economic situation in which he finds himself.

Let me turn to the conclusion of this study:

"Planning for health in the Gardner district will have little meaning without planning for transportation, housing, recreation facilities, day care centers, paid language interpreters, proper diets, improved public sanitation, etc. The district needs everything. It needs comprehensive social planning of which health is but one aspect. It is difficult to determine priorities of need due to the predominant influence of 'todayism' upon the respondents. At the end of the month when funds run out, rent and food have the highest priority of concern. If someone in the family is ill, then temporarily health care is the high priority. The daily mission is to clear the most immediate difficulties. There is need," the report continues, "for serious review of how health care is provided for economically deprived citizens. Alternate styles of delivery need be considered. Merely urging people to plug into existing forms of health care is not enough nor is it enough to challenge people who cannot meet the system to somehow beat the system. The solution always seems to be to mold people into present arrangements. Rarely is it deemed appropriate to change the arrangement. It is a mismatch, however, because life styles of the poor are often incompatible with medical care as presently organized and because current health care is not designed to reach the poor."

This study was done as a pilot project by Dr. Stanley Skillicorn, whom many of you know. I am sorry to report that the project was dropped because he felt that trying to focus on health alone was not enough.

So we have consumers of several varieties: middle class ones satisfied with their care, organized ones wielding power but without a viable data base, and the inarticulate "poor . . . huddled masses" who need far more than an improved Health Delivery System.

The Local Planners' Tasks

What about this group, you local planners? Great power is now legislatively vested in this coalition with consumer dominance. How will you use this power? You have been asked to build a framework for process planning, which you have done. You have been asked to accept an increasingly authoritative role for decision-making on health at the periphery, which you are doing. You will be asked to help restructure health delivery systems. What, then, are your expectations? Will you be informed of alternatives proposed, and know by whom they are proposed? Will you have a data base of human needs, not hearsay, not conventional wisdom, but *your* data base in *your* area? Will you continue to juggle your divergent factions, each with its driving and devious self-interest and keep their community trusteeship paramount? Will you have the breadth of vision to see the problems of health in a broad social context, ameliorating the former as part of a larger effort to correct the inequities of the latter? Finally, will you have the courage to act on an informed, considered decision that may mightily upset the parochial views of a vested institution in your area but ultimately be in the best interests of the public? We have time; we will see.

Using "the Market" to Shape the Care

Let me in conclusion tell you my own expectations.

Personal health is part of one's social milieu. It cannot be improved alone but must be improved in the context of other basic social conditions. The marketplace is the most sensitive device for registering one's individual needs. It is devoid of moralizing, limitless in its diversity of options, allows the one who *wants* do the choosing, rather than have someone choose for him, and draws no distinction among those who purchase. Its shortcomings are that needs are subservient to ability to pay and, therefore, it leaves no room for those who cannot pay.

Proposed solutions seek to dispense with the marketplace in health care. While this may correct some inequities, it will produce others because the forcing of contrivances that focus on economic considerations alone, may freeze mistakes into a monolithic system that stifles personal choice, diminishes quality and junks our pluralistic heritage.

The major problems of our health services are that we have a demand that exceeds both our fiscal and manpower resources. But many critics say that the fault really lies in the absence of an efficient and coordinated system. However, there is some evidence that people who can get adequate health care and can afford it are quite satisfied. Are we, then, better advised to spend our tens of billions on expanding manpower and providing the poor with purchasing power or on instituting a new delivery system for all. Manpower shortages are amenable by society's shifting its priorities so that it expands this natural resource. Distributive shortages are amenable by periods of obligatory service or financial incentives. Individual poverty or medical indigency may be amenable by the provision of funds or tax credits for those in need. Delivery systems that are inadequate for the culture of poverty may be reconstructed to meet these needs.

Ultimately, I believe we are off-target when we speak of the need for total reform in health delivery systems. The problem is not health, but poverty. The poor have no money. Therefore, their sociocultural state is one of deprivation in all things, including health.

Our affluent, post-industrial society cannot tolerate these gross social inequities. In the necessities of life, a basic minimum for all is economically feasible, just and timely.

THERAPY FOR IRON SALT INGESTION

"In the child suffering from iron salt ingestion, the most difficult decision is whether to use a therapeutic agent. Deferoxamine (Desferal®), a kelating agent which specifically binds iron, is relatively toxic and you don't want to use it unless it's absolutely necessary.

"In the January 1967 issue of CLINICAL CHEMISTRY, David Fisher describes a very simple test that should help you to decide. Although this test needs more evaluation, it is clearly useful and belongs in every emergency room. You take serum or plasma, mix it with a couple of reagents, and then after several minutes check the results. The test will tell you how much free iron there is, *i.e.*, iron not bound to transferin. If you have an appreciable amount of free iron, like 100 micrograms or more percent, then you're going to have to consider seriously using deferoxamine. If it's less than that, *i.e.*, if the amount of free iron is not greatly in excess of the ability of transferin to bind it, then you can treat the child safely in a conservative way, without using deferoxamine."

—DOUGLAS H. SANDBERG, M.D., Miami

Extracted from *Audio-Digest Internal Medicine,* Vol. 16, No. 19, in the Audio-Digest Foundation's subscription series of tape-recorded programs. For subscription information: 619 S. Westlake Ave., Los Angeles, Ca. 90057.